SOAP Note Template

**History of Present Illness (HPI):**

*This is your subjective/objective information. Include pertinent patient-reported information (including any* ***RELEVANT*** *social/family/surgical history, allergies, health maintenance, etc), labs, and vitals.*

**Medications:**

*Match patient medications to diagnoses and identify any pertinent labs or vitals related to that problem or medications.*

*Ask yourself:*

*Does every medication have a valid indication?*

*Is every medication appropriate for the condition being treated? (Remember to assess appropriateness of dose, frequency, etc.)*

*Are there any untreated conditions?*

|  |  |  |
| --- | --- | --- |
| **Chronic problem** | **Medications** | **Relevant labs, vitals, other notes** |
| 1. | 1.  2.  3. |  |
| 2. | 1.  2.  3. |  |
| 3. | 1.  2.  3. |  |
| 4. | 1.  2.  3. |  |
| 5. | 1.  2.  3. |  |

**Assessment and Plan:**

*This section should include an assessment and plan for the top 3 problems of the visit. If 3 problems were not addressed, include the next highest priority problem with an assessment and recommendations. Everything should be tied to a specific diagnosis. For example:*

**Type 2 diabetes with neuropathy**

Assessment: Uncontrolled with most recent A1c of 9.3%, likely related to non-adherence to medications.

Plan:

-Continue metformin 1000mg BID and glipizide 10mg BID as these are affordable to patient. Encouraged use of pill box and reminder alarm on phone to help with adherence to medications.

-Would like to start GLP-1. Would like once weekly product to help with adherence. Provided contact for Mission MAP.

-Foot exam today was normal.

-F/u in 1 month.